

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026634

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 114 Primary Registration District No. 5432 Registrar's No. 56

FILED AUG 15 1962

VS 300
Rev. 4/59

10360
28290

3
4 2
5 1
6
7 1
8 2
9 4201
10
11
12 91-0
13 6-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>FRANKLIN</u>		STATE <u>NEW JERSEY</u> COUNTY <u>BURLINGTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STANTON, MO.</u>		c. CITY OR TOWN <u>FLORENCE</u>	
Length of stay in 1b <u>MINUTES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MERANEC CAVERNS</u>		d. STREET ADDRESS (If outside, give location) <u>328 E. 6TH ST.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE MARSHALL</u>			4. DATE OF DEATH Month Day Year <u>AUG. 12 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 20, 1914</u>
9. AGE (last birthday) <u>50</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AIRCRAFT MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>	11. BIRTHPLACE (City and state or country) <u>TRENTON, N.J.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>HENRY MARSHALL</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>NAOMI ELLIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>NAOMI MARSHALL, FLORENCE N.J.</u>		Address <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>
IMMEDIATE CAUSE (a) <u>Barotraum Ocular</u>			<u>Coronary sclerosis?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis?</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>Aug 12, 1962</u> and last saw her/him alive on <u>Aug 12, 1962</u> . Death occurred at <u>3:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>26 W. Main Street, Florence, N.J.</u>	
22c. DATE SIGNATURE <u>8/13/62</u>		22d. ADDRESS (Degree or title) <u>[Signature]</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>8/13/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR LAKE CEM. FLORENCE N.J.</u>	
24. FUNERAL DIRECTOR <u>WAPLES FUNERAL HOME, BURLINGTON</u>		25. DATE RECD. BY LOCAL REG. <u>8-13-1962</u>	
26. REGISTRAR'S SIGNATURE <u>William Cowan</u>		26. REGISTRAR'S SIGNATURE <u>William Cowan</u>	

USE BLACK INK OR TYPEWRITER RIBBON

MS AUG 1 5 1962

FEB 7 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harmon Jr. Eaton

Licensed Embalmer No. 5060

P. O. Address Fullivan, Miss.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.